

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1 (M)</p> <p>06739</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>06738</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>CARROLL</u> MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u></p>				
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p><u>Sykesville</u></p>			<p>c. LENGTH OF STAY IN 1b</p> <p><u>4 months</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p><u>Balto.</u> <u>30-4</u></p>				
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><u>Springfield State Hospital</u></p>					<p>d. STREET ADDRESS</p> <p><u>3037 Abell Ave, Baltimore Md.</u></p>			<p>e. IS RESIDENCE ON A FARM?</p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>EDWARD</u> Middle <u>AMOS</u> Last <u>BAILEY</u></p>					<p>4. DATE OF DEATH</p> <p>Month <u>May</u> Day <u>14</u> Year <u>1966</u></p>				
<p>5. SEX</p> <p><u>Male</u></p>		<p>6. COLOR OR RACE</p> <p><u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p><u>3-22-83</u></p>		<p>9. AGE (In years last birthday)</p> <p><u>83</u> yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Machinist</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p><u>Machinist</u></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country)</p> <p><u>Maryland</u></p>			<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>U.S.A.</u></p>		
<p>13. FATHER'S NAME</p> <p><u>John R. Bailey</u></p>					<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Annie Boston</u></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p> <p><u>No</u></p>		<p>16. SOCIAL SECURITY NO.</p> <p><u>216-07-2885</u></p>		<p>17. INFORMANT</p> <p><u>Hospital Record.</u></p>			<p>Address</p>		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Pneumonia</u></p> <p><u>4500</u> DUE TO (b) <u>Generalized arterio-sclerosis</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)</p>								<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>days</u></p> <p><u>years.</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>								<p>19. WAS AUTOPSY PERFORMED?</p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>									
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>									
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. _____ p.m. <u>19</u></p>			<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		
<p>21. I certify that (I) (this hospital) attended the deceased from <u>1-10-</u>, <u>1966</u>, to <u>5-14</u>, <u>1966</u>, that (I) (we) last saw the deceased alive on <u>5-14</u>, <u>1966</u>, and that death occurred at <u>4:30 AM</u>, from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE</p> <p><u>Frances Reid Nabors</u>, M.D.</p>					<p>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></p>		<p>22b. DATE SIGNED</p> <p><u>5/14/66</u></p>		
<p>22c. PHYSICIAN'S NAME (Type)</p> <p><u>Frances Reid Nabors</u></p>					<p>22d. ADDRESS</p> <p><u>Springfield State Hosp. Sykesville Md.</u></p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>		<p>23b. DATE THEREOF</p> <p><u>5-17-66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><u>Woodlawn</u></p>		<p>23d. LOCATION (City, town or county) (State)</p> <p><u>Woodlawn Md.</u></p>			
<p>24. FUNERAL DIRECTOR</p> <p><u>H.W. Jenkins &amp; Sons Co. 4905 York Rd.</u></p>					<p>25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE</p> <p>DATE <u>MAY 17 1966</u> <u>Charles J. J.</u></p>				

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EDWARD ALBERT ROBERT



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06740

06734

<b>1. PLACE OF DEATH</b> e. COUNTY <b>CARROLL</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b> <span style="float: right;">44 YEARS</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ROUTE #2</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>CARROLL</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b> d. STREET ADDRESS <b>ROUTE #2</b> <span style="float: right;">06-1</span> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>THOMAS</b> Last <b>BANKERT</b>				<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>12</b> Year <b>1966</b>					
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>NOV 2 1898</b>		<b>9. AGE</b> (In years, last birthday) <b>67</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>DAIRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CARROLL MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>GEORGE O. BANKERT</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA MISSOURI LAMBERT</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-03-5394</b>		<b>17. INFORMANT</b> Address: <b>MRS JOHN BANKERT WESTMINSTER MARYLAND</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>ACUTE CORONARY THROMBOSIS</b> 4201 DUE TO <b>ARTERIOSCLEROTIC CARDIO-CEREBRAL VAS. DIS. 2 YEARS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>MAY 12 1966</b> <b>to</b> <b>MAY 12 1966</b> <b>that (I) (we) last saw the deceased alive on</b> <b>MAY 12 1966</b> <b>and that death occurred at</b> <b>12:00 PM</b> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Daniel J. Welliver</b> M.D.					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>5-12-66</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DANIEL J. WELLIVER</b>					<b>22d. ADDRESS</b> <b>14 RIDGE RD WESTMINSTER MD</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>5/15/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Marys Cemetery</b>			<b>23d. LOCATION (City, town or county) (State)</b> <b>Silver Run, Carroll Co. Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Richard A. Little</b>					<b>ADDRESS</b> <b>Littlestown, Pa.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 16 1966</b>		
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>									

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00330

CARROLL MARYLAND

RURAL WESTMINSTER 14 YEARS RURAL WESTMINSTER  
ROUTE #5

JOHN THOMAS BANKERT MAY 15 1907  
MADE WHITE NOV 2 1898

MECHANIC DAIRY CARROLL MARYLAND USA  
GEORGE O. BANKERT ANNA MISSOURI LAMBERT

WESTMINSTER MARYLAND  
ACUTE CORONARY THROMBOSIS

ATERIOSECTIC CORPUS CEREAL AND DISSEMINATED

MAY 15 1907  
DANIEL I. WELLS  
MAY 15 1907  
MAY 15 1907

MADE WHITE NOV 2 1898  
MAY 15 1907



06741

CERTIFICATE OF DEATH

06735

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>2 mon. / 4 das.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3925 Beech Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGIANA</b> Middle <b>ELLIOTT</b> Last <b>BAUER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-86</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gvt. Employee (retired)</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>XX ELLIOTT X Bauer, Edward T.</b>	
14. MOTHER'S MAIDEN NAME <b>Ida X (Maiden Name Unknown) X Elliott</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary Occlusion</b> (c) <b>Arteriosclerotic Cardio-Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Day</b> <b>Bay</b> <b>Yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS assoc. with cerebral arteriosclerosis with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>3-9-66</b> , 19 <b>66</b> to <b>5/13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/13/66</b> , 19 <b>66</b> , and that death occurred at <b>4:30 P.M.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>Dr. Antonius Glahn</b>		22b. DATE SIGNED <b>5/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5/14/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>	
ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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VR A15 (4)  
20 M 1/66

06742

CERTIFICATE OF DEATH

06736

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 mos. 22 dys.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>7407 Carroll Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANDREW (NMN) BENNETT Sr.</b>		4. DATE OF DEATH Month Day Year <b>May 8 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-83</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Benyo</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-34-3178A</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart &amp; Kidney Failure</b> DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease &amp; nephrosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with alcohol intoxication with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>months</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-16-66</b> , 19__ to <b>5-8-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-8-66</b> , 19__, and that death occurred at <b>10:55 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Octavio A. Ruiz</b>		22b. DATE SIGNED <b>5-8-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>May 11-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>East Swamp Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Quakertown, Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>MAY 12 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06743  
CERTIFICATE OF DEATH  
06737

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Sykesville</b> c. LENGTH OF STAY IN b <b>0y 0m 20dy</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Manchester 21102</b> d. STREET ADDRESS <b>409 York Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Elmer</b> Last <b>Bollinger</b>		4. DATE OF DEATH Month <b>5</b> Day <b>2</b> Year <b>1966</b>						
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-86</b>	9. AGE (in years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Bollinger</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Wilhelm</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>215-32-6907</b>	17. INFORMANT <b>Hospital Records</b> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism (cite of origin unknown)</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, senile brain disease</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>--</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>--</b> 19 p.m. <b>--</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>		20f. (City or town) (County) (State) <b>--</b>		
21. I certify that (X) (this hospital) attended the deceased from <b>4-12</b> , 1966, to <b>5-2</b> , 1966, that (he)(we) last saw the deceased alive on <b>5-2</b> , 1966, and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>Heinz H. Klaatsch</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-2-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Heinz H. Klaatsch, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/4/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel</b>		23d. LOCATION (City, town or county) (State) <b>Manchester Md.</b>		
24. FUNERAL DIRECTOR <b>Tipton-Eline</b>		ADDRESS <b>Hampstead, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
06734					06738									
Item #9 Film #6377 5/27/66														
1. PLACE OF DEATH a. CDUNTY <i>Carroll</i>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30-11</i>									
c. LENGTH OF STAY IN 1b <i>4 yrs. 5 months</i>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Springfield State Hospital</i>					d. STREET ADDRESS <i>1901 E. 28<sup>th</sup> St. Baltimore 18 Md.</i>									
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Bernard</i> Middle <i>Bonn</i> Last					4. DATE OF DEATH Month <i>May</i> Day <i>15</i> Year <i>1966</i>									
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-17-1879</i>		9. AGE (In years last birthday) <i>87/86</i> yrs.						
						IF UNDER 1 YEAR		IF UNDER 24 HRS.						
						Months		Days						
						Hours		Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>					11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>														
13. FATHER'S NAME <i>William Bonn</i>					14. MOTHER'S MAIDEN NAME <i>Catherine</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>218-36-4884</i>					17. INFORMANT <i>Hospital Records</i> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>334X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Generalized arteriosclerosis - Arterio</i> DUE TO (c) <i>sclerotic heart disease</i>										INTERVAL BETWEEN ONSET AND DEATH <i>Day</i> <i>years</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CBS with cerebral arterio-sclerosis.</i>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <i>11-24</i> , 19 <i>61</i> , to <i>5-15</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-15</i> , 19 <i>66</i> , and that death occurred at <i>5:00</i> M, from the causes and on the date stated above.														
22a. SIGNATURE <i>Suha Ozgun</i>					22b. DATE SIGNED <i>5-15-66</i>									
22c. PHYSICIAN'S NAME (Type) <i>SUHA OZGUN</i>					22d. ADDRESS <i>Springfield State Hosp. Sykesville Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF <i>5/18/66</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Immanuel Cem</i>				
23d. LOCATION (City, town or county) (State) <i>Baltimore</i>														
24. FUNERAL DIRECTOR <i>W. Steyer - Burial</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
DATE <i>MAY 19 1966</i>														

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MAY 13 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06745					06739						
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster RD 3</b> c. LENGTH OF STAY IN 1b <b>15 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <th colspan="5">2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster RD #3</b> d. STREET ADDRESS <b>06-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></th>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster RD #3</b> d. STREET ADDRESS <b>06-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>BAYNE</b> Middle <b>BROWN</b> Last			4. DATE OF DEATH <b>MAY</b> Month <b>13</b> Day <b>1966</b> Year								
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1898</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>auto body &amp; fender repair man</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>auto body &amp; fender repair man</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Howard County, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Albert E. Brown</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Bayne</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>			16. SOCIAL SECURITY NO. <b>213-01-9219</b>		17. INFORMANT <b>Mrs. Charles B. Brown</b> Address <b>same</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> <b>4201</b> DUE TO (b) <b>Arterio Sclerosis &amp; moderate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>8-29-63</b> , 1963 to <b>5-13-</b> , 1966, that (I) (we) last saw the deceased alive on <b>4-28</b> , 1966, and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>W. L. Spencer</b> M.D.					22b. DATE SIGNED <b>5-14-66</b>		22c. PHYSICIAN'S NAME (Type) <b>W. L. Spencer</b>				
22d. ADDRESS <b>Westminster, Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE THEREOF <b>May 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Westminster, Maryland</b>				
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr.</b>			ADDRESS <b>Westminster, Md</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

06746

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06740

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>18yrs.3mo.22days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1844 W. Saratoga Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BEULAH</b> Middle <b>(NMN)</b> Last <b>BRUNNER</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>27</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-2-1891</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Addison Cephus Fox</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Bell</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records</b>		Address <b>Springfield State Hospital, Sykesville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> <b>4221</b> DUE TO <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pulmonary Emphysema</b> (c) <b>Old Granuloma, left lower lung</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>2-5</b> , 19 <b>48</b> , to <b>5-27</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-27</b> , 19 <b>66</b> , and that death occurred at <b>5:50 PM</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>SP Wise</b>		22b. DATE SIGNED <b>5-27-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Samuel P. Wise M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/31/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn Md</b>	
24. FUNERAL DIRECTOR <b>Witzke F. H. 4101 Edwards Ave.</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS	

MEDICAL CERTIFICATION

1874

1874

Baltimore City Maryland

CARROLL

1874. Dec. 25th Baltimore

Sykesville

104 W. Baltimore Street

Baltimore State Hospital

MAY

RECEIVED

(MAY)

RECEIVED

1874

Female White

Housewife

Housewife

Admission Copy No.

Headache

None

None

Chronic Catarrh of the Uterus

Chronic Catarrh of the Uterus

Chronic Catarrh of the Uterus

Chronic Catarrh of the Uterus

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Baltimore State Hospital

Sykesville, Maryland

1874



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>21 yr. 15 da.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>414 Pitman Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Erna</b> Middle <b>Mary</b> Last <b>Clemens</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	9. AGE (In years last birthday) <b>50</b> 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Stilson</b>		14. MOTHER'S MAIDEN NAME <b>Edna Lewis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Hospital Records</b> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia - 5 days</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial Hypertension disease</b> (b) <b>491X</b> (c) <b>X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain syndrome with right Hemiparesis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/2/45</b> , 19 <b>66</b> , to <b>5/17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/16</b> , 19 <b>66</b> , and that death occurred at <b>12:05 a.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Manereet Fuangvudhiran</i>		22b. DATE SIGNED <b>5/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Manereet, Fuangvudhiran, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital-Sykesville, Md.</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/20/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKE VIEW MEM. PARK.</b>	23d. LOCATION (City, town or county) (State) <b>RANDELLSTOWN Md.</b>
24. FUNERAL DIRECTOR <i>Frank Della Torre</i>		25a. REC'D BY REGISTRAR <b>322 S. HIGH ST.</b> DATE <b>MAY 20 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06748					06742						
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>			c. LENGTH OF STAY IN 1b <u>2y 5m 26d</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City, 21217</u> <u>30-4</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					d. STREET ADDRESS <u>803 Chauncey Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Will</u> First <u>NMN</u> Middle <u>Cook</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1966</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?-?-1907</u>		9. AGE (In years last birthday) <u>58-?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown - laborer?</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>unknown -- North Carolina? USA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>443X</u> DUE TO (b) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome of unknown or unspecified cause without qualifying phrase.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>2 YEARS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>---</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>		20f. (City or town) (County) (State) <u>--</u>				
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>11-7-</u> , 19 <u>63</u> , to <u>5-3-</u> , 19 <u>66</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>5/3</u> , 19 <u>66</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>S.P. Wise III</u>					22b. DATE SIGNED <u>5-3-66</u>		22c. PHYSICIAN'S NAME (Type) <u>S.P. Wise III</u>				
22d. ADDRESS <u>Springfield State Hospital</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>---</u>			23b. DATE THEREOF <u>May 9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Y. 2nd, med. Schol</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, Md.</u>				
24. FUNERAL DIRECTOR <u>Frank H. Newell</u> <u>Per Philip Knatz</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1900  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899  
ALBANY: J. B. LEECH, STATE PRINTER.  
1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06749					06748				
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>3 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balt. more</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3108 Walbrook Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Laurence Butler Coskery</b>					4. DATE OF DEATH Month Day Year <b>MAY 18 1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-27-80</b>		9. AGE (in years last birthday) <b>85 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		
13. FATHER'S NAME <b>Henry G. Coskery</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Sittler</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>419-05-6732</b>		17. INFORMANT <b>Patient's Record - Springfield State Hospital</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Coronary arteriosclerosis</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Days  Years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>5-24-63</b> , 19 <b>63</b> , to <b>5-18</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-18</b> , 19 <b>66</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Frances Reid Nabors</b>					22b. DATE SIGNED <b>5/18/66</b>			22c. PHYSICIAN'S NAME (Type) <b>FRANCES REID NABORS</b>	
22d. ADDRESS <b>SYKESVILLE, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-20-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WILSON PARK</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, Md.</b>			
24. FUNERAL DIRECTOR <b>Funeral Home</b>					25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE <b>5-19-66</b>					DATE <b>MAY 24 1966</b>				

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1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>26yrs. 5mos. 28days.</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1519 Retreat St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (Lucia) LUCILLE		4. DATE OF DEATH Month Day Year <b>MAY 11 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-17-03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewingfactory worker; saleslady</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Fitzpatrick</b>		14. MOTHER'S MAIDEN NAME <b>Mary Colwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia by occlusion of nose &amp; mouth by patient</b> <b>527.2</b> lying on right side and nose DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute edema and congestion of lungs</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Chronic brain syndrome associated with convulsive disorder, with psychotic reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William Speicher</i>		22. DATE SIGNED <b>5-11-66</b>	
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M. D.</b>		23a. REC'D BY REGISTRAR <b>MAY 17 1966</b>	
23b. DATE THEREOF <b>5/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		23e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Balto. St.</b>		25. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. LENGTH OF STAY IN 1b <b>50 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>83 Washington Road</b>					d. STREET ADDRESS <b>83 Washington Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>MAY</b> Last <b>DITMAN</b>			4. DATE OF DEATH Month <b>May</b> Day <b>22</b> , Year <b>1966</b>						
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 5, 1880</b>		9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>06</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Marston, Carroll Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Franklin</b>					14. MOTHER'S MAIDEN NAME <b>Mary E. Nusbaum</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>			16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Mrs. Helen D. Harbaugh, same</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral Hemorrhage</b> <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cardio-Vascular disease</b> DUE TO (c) <b>Arterio-sclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>3 years</b> <b>10 years</b>	
								PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>—</b> p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 22</b> , 19 <b>66</b> , to <b>May 22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 22</b> , 19 <b>66</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>C. L. Billingslea</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-23-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>C. L. Billingslea</b>					22d. ADDRESS <b>Westminster, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>nr Westminster, Maryland</b>		
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr., Westminster, Md.</b>					ADDRESS <b>Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

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UNITED STATES OF AMERICA

Carroll

Carroll

Carroll

Washington

Carroll

Carroll

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>1yr.7mo.11da.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital Sykesville, Maryland</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3000 Rayner Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Emma Felica Evans Dudley</b>			4. DATE OF DEATH <b>May 24, 1966</b>		9. AGE (In years last birthday) <b>73</b> yrs.				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-19-92</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			11b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Evans</b>					14. MOTHER'S MAIDEN NAME <b>Emmaline Hammond</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records</b> Address <b>Springfield State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Coronary Arteriosclerosis</b> DUE TO (c) <b>Bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 13, 1964</b> to <b>May 24, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 24, 1966</b> , and that death occurred at <b>9:20 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Ilse Kamm</b>			22b. DATE SIGNED <b>May 24, 1966</b>			22c. PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M.D.</b>			
22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>			23b. DATE THEREOF <b>5/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTO MD</b>		
24. FUNERAL DIRECTOR <b>Marion Payne</b>			ADDRESS <b>638 N Gilman St</b>			25a. REC'D BY REGISTRAR <b>MAY 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

100710

100710

Baltimore

Maryland

CARDINAL

Baltimore

11-19-55

11-19-55

5000 N. Yuma Avenue

Springfield State Hospital  
Springfield, Maryland

Same Address as above

11-19-55

11-19-55

Maryland

None

Springfield State Hospital

George Evans

Records

Springfield State Hospital

None

None

Arteriosclerotic Heart Disease

Severe Coronary Arteriosclerosis

Chronic Brain Syndrome

Chronic Brain Syndrome associated with cerebral arteriosclerosis  
with psychotic reaction.

Oct. 15, 1955

May 24, 1956

May 24, 1956

Springfield State Hospital  
Springfield, Maryland

Line 100, N.D.

MAY 20 1956



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wheeler Chemist, Inc</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <i>Penna</i> f. COUNTY <i>York</i> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hannover</i> h. STREET ADDRESS <i>138 Broadway</i> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Howard William Flickinger</i> First Middle Last 4. DATE OF DEATH <i>May 23 1966</i> Month Day Year		5. SEX <i>Male</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Jan. 10, 1903</i> 9. AGE (In years last birthday) <i>63</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Body Work</i> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <i>Penna</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Jonas Calvin Flickinger</i> 14. MOTHER'S MAIDEN NAME <i>Ada Jane Hintz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <i>176-05-3090</i> 17. INFORMANT <i>Miss Helen R Flickinger</i> Address <i>Hannover Pa.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis (acute)</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Sclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>6 m to 1 yr</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Walter Speicher</i> M.D. EXAMINER'S NAME (Type) <i>Walter Speicher</i> Address (Street, city, town or county) <i>135 E. Main Street, York, Pa.</i> 22. DATE SIGNED <i>5-25-66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>May 26-1966</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven</i> 23d. LOCATION (City, town or county) <i>Hannover Pa.</i>		25a. REC'D BY REGISTRAR <i>MAY 26 1966</i> DATE 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>Tipton Eline Funeral Home</i> ADDRESS <i>Hampstead Md</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00330

RECEIVED - JAMES'S GENTILE'S DEATH

FOR STATE  
HEALTH DEPT.

MAY 21 1966

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06756

06748

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster RD #4</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster RT #4</u>			
c. LENGTH OF STAY IN 1b <u>77 years</u>				d. STREET ADDRESS <u>Brehm Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brehm Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS CONRAD FREBERTSHAUSER</u>				4. DATE OF DEATH Month Day Year <u>MAY 31 19 66</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1889</u>		9. AGE (In years last birthday) <u>77 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired felt mill employee</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam C. Frebertshauser</u>				14. MOTHER'S MAIDEN NAME <u>Mary Etta Jawney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-07-3846</u>		17. INFORMANT Address <u>Mrs. Francis C. Frebertshauser</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Thrombosis (acute)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. E. Speck</u>				22. DATE SIGNED <u>5-31-66</u>			
EXAMINER'S NAME (Type) <u>W. E. Speck</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Luster's Cemetery Westminster RD #4</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md.</u>				25a. DEC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03715

NEW ALBANY, INDIANA, DECEMBER 1, 1901

03715

THE STATE  
OF INDIANA

1

JUN 3 1902

06755

CERTIFICATE OF DEATH

06749

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Marylan d</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Route 1</b>			c. LENGTH OF STAY IN 1b <b>10 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - New Windsor 06-1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural New Windsor Route 1</b>				d. STREET ADDRESS <b>Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Augustus</b> Middle <b>Gibson</b> Last <b>Gibson</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 30, 1895</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Gibson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>219-03-2680</b>		17. INFORMANT Address <b>New Windsor, Md.</b> <b>Mrs. Delilah H. Gibson Route 1</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> DUE TO (b) <b>Carcinoma Prostate</b> DUE TO (c) <b>(original site)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/10/65</b> , 19__, to <b>5/9/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5/9/66</b> , 19__, and that death occurred at <b>12:34 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>M. E. Robertson</b>				22b. DATE SIGNED <b>5/10/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. M. E. Robertson</b>	
22d. ADDRESS <b>New Windsor, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/14/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>C. M. Waltz Box 241 Sykesville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

92786

2572

300 81 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

06756

CERTIFICATE OF DEATH

06750

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN lb <b>ly. 9m. 6d.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>6403 Sefton Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Regina Marie Grossman</b>		4. DATE OF DEATH Month Day Year <b>5 9 19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/18/95</b>
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ambrose Spangler</b>		14. MOTHER'S MAIDEN NAME <b>Anna Eppler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 603x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal insufficiency</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>8/31</b> , 19 <b>64</b> , to <b>5/9</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>5/9</b> , 19 <b>66</b> , and that death occurred at <b>6:55A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Frances Reid Nabors</b>		22b. DATE SIGNED <b>5/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/12/66.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

00350

00350

PROSTATE OF DEATH

Ca. toll

Notified

17. 30. 00. 1840

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

1000 Cotton Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Miller's Station, md.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester, md</i>		c. LENGTH OF STAY IN 1b <i>18 yrs 5 mo</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Longview Nursing Home Manchester, md</i>		d. STREET ADDRESS <i>none</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mary Elizabeth Hain</i>		4. DATE OF DEATH Month Day Year <i>5 8 1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 25, 1876</i>
9. AGE (In years last birthday) <i>89 yrs.</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Carroll, md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John Ralph Hain</i>		14. MOTHER'S MAIDEN NAME <i>Magdalena Hain</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-48-4376</i>	
17. INFORMANT <i>Patent at time of adm. - husband.</i>		Address <i>Taken from</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <i>Chronic Myocarditis</i> <i>Arteriosclerotic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <i>9</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 11</i> , 19 <i>47</i> , to <i>May 8</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>May 8</i> , 19 <i>66</i> , and that death occurred at <i>5 A.M.</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Joseph E. Bush MD</i>		22b. DATE SIGNED <i>MAY 11 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		22d. ADDRESS <i>Hampstead Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5-10-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Bartholomew's</i>	23d. LOCATION (City, town or county) (State) <i>Manchester Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tipton-Eline</i>		25a. REC'D BY REGISTRAR <i>MAY 11 1966</i>	
ADDRESS <i>Hampstead, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08521

08521

MAY 11 1968

11 MAY 1968

11 MAY 1968

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

<div style="text-align: center;"> <p>1 (M)</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>06758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06752</p> </div>											
1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>7 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RD #4</u>				06-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridge Rd. off of Carrollton Road</u>						d. STREET ADDRESS <u>(Mexico)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HILDA ELIZABETH HAINES</u>						4. DATE OF DEATH <u>MAY 23 1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5, 1945</u>		9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student also worked in Canning factory</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Westminster Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Denton S. Haines</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Marie Horn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>	
16. SOCIAL SECURITY NO. <u>219-44-6649</u>		17. INFORMANT <u>Mrs Charlotte H. Dayhoff</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>974X</u> (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Choked by rope around neck fastened to patch limb &amp; dropped down</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>5/23 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>  </u> at work <u>  </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Carrollton</u> (County) <u>Carroll</u> (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <u>W. Glenn Speicher</u>		22. DATE SIGNED <u>5-24-66</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Leisters Cemetery</u>		23d. LOCATION (City, town or county) <u>Rural Westminster Md</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		25c. NAME OF CEMETERY OR CREMATORY <u>Leisters Cemetery</u>		25d. LOCATION (City, town or county) <u>Rural Westminster Md</u>		25e. DATE <u>MAY 27 1966</u>	

5250

35523



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
06759					08266									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <b>Carroll</b>					a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>					b. COUNTY <b>Baltimore</b>									
c. LENGTH OF STAY IN 1b <b>2 months-2 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>3338 W. Belvedere Ave.</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. AGE (In years last birthday)			6. IF UNDER 1 YEAR					
First <b>Geneva</b>			Middle <b>Lorraine</b>			Last <b>Hall</b>			Day <b>May</b>					
5. SEX <b>Female</b>			6. COLOR OR RACE <b>white</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>2-19-98</b>					
9. AGE (In years last birthday) <b>68</b> yrs.			10. IF UNDER 1 YEAR Months <b>2</b>			11. IF UNDER 24 HRS. Days <b>20</b>			12. IF UNDER 24 HRS. Hours <b>19</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Joseph E. Evans</b>					14. MOTHER'S MAIDEN NAME <b>Catherine</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>216-09-8940</b>					17. INFORMANT <b>Records-Springfield State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laennec's Cirrhosis of Liver</b> <b>5811</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Bronchopneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>day</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <b>3-18</b> , 19 <b>66</b> to <b>5-20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-20</b> , 19 <b>66</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.										22b. DATE SIGNED <b>5-20-66</b>				
22a. SIGNATURE <b>Rita S. Glahn</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <b>RITA S. GLAHN</b>					22d. ADDRESS <b>SPRINGF. STATE HOSP.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF <b>May 24, 1966</b>					23c. NAME OF CEMETERY OR CREMATORY <b>St. Lawrence Park Cemetery</b>				
23d. LOCATION (City, town or county) (State) <b>Newell Funeral Home Pikesville - 8. Md.</b>					23e. REC'D BY REGISTRAR <b>Charles Judge</b>					23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

005811

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06760

06753

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rt. 2- Box 141A- Gamber, Rd.</b>				d. STREET ADDRESS <b>Rt. 2- Box 141 A- Gamber Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>S.</b> Middle <b>Cleveland</b> Last <b>Hammett, Sr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1886</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Head Shipping Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Butler Bros.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>St. Marys Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Hammett</b>				14. MOTHER'S MAIDEN NAME <b>Jane Bowen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-10-0565</b>		17. INFORMANT <b>Mrs. Ruth G. Hammett, Finksburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic C-V Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>  <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>none</b> 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) <b>none</b>	(County)	(State)		
21. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>5-1-66</b> , 19 <b>66</b> , to <b>5-28-66</b> , 19 <b>66</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>5-25-66</b> , 19 <b>66</b> , and that death occurred at <b>8:45P</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>D. D. Caples</b>			22b. DATE SIGNED <b>5-31-66</b>		22c. PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		
22d. ADDRESS <b>6 Hanover Rd., Reisterstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/31/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olive Randallston</b>	23d. LOCATION (City, town or county) <b>Randallston Md</b>	(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Forrest Myers</b>			25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

82580

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06761

## CERTIFICATE OF DEATH

06754

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN lb <b>2 wks.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>M.</b> Last <b>HANN</b>		4. DATE OF DEATH Month <b>5</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1892</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWF.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Rohrbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Rohrbaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-01-6705D</b>	
17. INFORMANT <b>Mr. Vernon Hann,</b>		Address <b>Lineboro, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEFT VENTRICULAR FAILURE</b> <b>4200</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/29</b> , 1966, to <b>5/9</b> , 1966, that (I) (we) last saw the deceased alive on <b>5/9</b> , 1966, and that death occurred at <b>11:45</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <i>Vernon J. Hann</i>		22b. DATE SIGNED <b>5/10/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/12/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Manchester Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Manchester Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton-Eline</b>		25a. REC'D BY REGISTRAR <b>MAY 13 1966</b>	
ADDRESS <b>Hampstead, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

103524

STATEMENT OF DEATH

103524

AM 11:00 PM  
10/1/54



## CERTIFICATE OF DEATH

06752

06755

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>44 yrs</b>		01-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Polk Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>?</b> Last <b>Hausman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/96</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Hausman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Schilling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>491X</b> (b) <b>Bronchopneumonia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, manic type.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>6/9/66</b> to <b>May 13, 1966</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>May 13, 1966</b> , and that death occurred at <b>8:30 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Naci Buyukunsal, M.D.</b>		22b. DATE SIGNED <b>5/13/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Naci Buyukunsal, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/17/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1966</b>	
ADDRESS <b>Cumb. Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF DATE

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Allegany

Marshall

Carroll

Chesapeake

Warren--Warrenton

Half Horse

Bozonsfield Street Hospital

Hammond

Madison

Wayne

White

Female

Maryland

None

Interstate Association

John Hansen

Specific--In Hospital--recovered, Warrenton

Unknown

20

500

Carroll (Albion)

0.75

Transplantation

Transplantation, same type.

Warrenton, Maryland

Warrenton, Maryland

MAY 19 1900

## CERTIFICATE OF DEATH

06763

06756

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2mos. 14dys.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>10107 McKenney Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALETHE</b> Middle <b>(NMN)</b> Last <b>HERRMANN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-1897</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>19</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Larch</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor McKutchen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Terminal bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b> <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-17-66</b> to <b>5-1-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-1-66</b> 19__, and that death occurred at <b>10:15 PM</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>5-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Pt. Geo. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co.</b>		ADDRESS <b>Wash DC</b>	
25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06754					06757				
1. PLACE OF DEATH a. COUNTY <u>Carrall</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carrall</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural) 06-1</u> d. STREET ADDRESS <u>RFD 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>F</u> Middle <u>Hersh</u> Last			4. DATE OF DEATH <u>May</u> Month <u>25</u> Day <u>1966</u> Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 19, 1879</u> 9. AGE (In years last birthday) <u>86</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Hersh</u>					14. MOTHER'S MAIDEN NAME <u>Magdalena Therit</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>220-01-0428</u>		17. INFORMANT <u>Mrs. Minnie Hersh, Manchester, Md.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>4221</u> DUE TO (b) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>adenocarcinoma prostate</u> 2 days									INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>May 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> , 19 <u>66</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>W. H. Foard</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/26/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard</u>			M.D. <u>M.D.</u>		22d. ADDRESS <u>Manchester, Md.</u>				
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Manchester Md.</u>		
24. FUNERAL DIRECTOR <u>Tipton-Eline</u>			ADDRESS <u>Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

00757

REMITTANCE OF DEATH

00757

1975-1976

1975-1976

1975-1976

1975-1976

1975-1976

1975-1976



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06758

06758

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN ID <b>2yrs. 1mo. 2dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>929 Franklintown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL HENRY HOWARD</b>			4. DATE OF DEATH Month Day Year <b>MAY 5 19 66</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-1889</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>John Henry Howard</b>			14. MOTHER'S MAIDEN NAME <b>Harriett Ann Gaither</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-12-4908</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>CBS assoc. with cerebral arteriosclerosis, without qualifying phrase</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>W. Glenn Speicher</i>		EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M. D.</b>		22. DATE SIGNED <b>5-6-66</b> <i>Charles Judge</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carroll</b>			
23d. LOCATION (City, town or county) <b>Balto Md</b>		24. FUNERAL DIRECTOR <b>Rev. H. Nelson</b>		25a. REC'D BY REGISTRAR <b>1348 N. Calhoun</b>			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>MAY 10 1966</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE  
OF NEW YORK

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MAY 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06766					06759				
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN ID <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3807 Barrington Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>BESSIE HENRIETTA SMITH HULL</b>			First Middle Last <b>HULL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-18-1886</b>		9. AGE (In years last birthday) <b>79</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. Smith Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Carrie W. Haas</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>216-10-6027D</b>		17. INFORMANT <b>Records, Springfield State Hospital</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10-19-65</b> , 19__, to <b>5/12/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-12</b> 19 <b>66</b> , and that death occurred at <b>11:35</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					22b. DATE SIGNED <b>5/12/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Sykesville, Maryland</b>					22d. ADDRESS <b>Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/16/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Maryland</b>		
24. FUNERAL DIRECTOR <b>Wm. F. Tipton &amp; Sons</b> Address <b>Baltimore, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06767		06760	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> c. LENGTH OF STAY IN b. <u>6 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ROUTE #4 BOX 17</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> d. STREET ADDRESS <u>ROUTE #4 BOX 17</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES CLAUDE JACKSON</u>		4. DATE OF DEATH Month Day Year <u>MAY 9 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 11, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>77</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE Co., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>JAMES WESLEY JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>JANE S. ALGIRE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-8112</u>	
17. INFORMANT Address <u>MRS. JAMES JACKSON</u> <u>ROUTE #4 WESTMINSTER MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RECTUM.</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>9 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 9</u> to <u>MAY 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>MAY 9</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel I. Welliver</u> 22c. PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>		22b. DATE SIGNED <u>5/9/66</u> 22d. ADDRESS <u>19 RIDGE RD WESTMINSTER MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/12/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>MAY 10 1966</u>	

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STATE OF TEXAS  
COUNTY OF DALLAS

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U. S. State & Cons. Relations



CERTIFICATE OF DEATH

06768

06761

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN lb <b>21 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>NMN</b> Last <b>Kayer</b>		4. DATE OF DEATH Month <b>5</b> Day <b>10</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/5/81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>85</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Mackert</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-46-9043</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Mitral insufficiency</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/19/ 1966</b> to <b>5/10/ 1966</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>5/10/ 1966</b> , and that death occurred at <b>2:00 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <i>Naci N. Buyukunsal</i>		22b. DATE SIGNED <b>5/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/13/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hampstead Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hampstead, Md.</b>
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home 4210 Belair Road</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06769

## CERTIFICATE OF DEATH

06762

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>9yr, 3mo, 4das</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>814 E. 41st St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward Gilbert Kemper</b> First Middle Last 4. DATE OF DEATH <b>May 3 1966</b> Month Day Year				5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>8-27-23</b> 9. AGE (in years last birthday) <b>42</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>August A. H. Kemper</b> 14. MOTHER'S MAIDEN NAME <b>Katherine E. McNeal</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>Records of Springfield State Hospital</b> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> 5704 DUE TO (b) <b>Fecal impaction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental defective, mongolism</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>1-29-57</b> , 19 <b>57</b> to <b>5-3-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> , 19 <b>66</b> , and that death occurred at <b>6:30 a.m.</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>SP Wise III</b> 22b. DATE SIGNED <b>5-3-66</b> 22c. PHYSICIAN'S NAME (Type) <b>Samuel P. Wise III, M.D.</b> 22d. ADDRESS <b>Springfield State Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>May 5, 1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b> 23d. LOCATION (City, town or county) (State) <b>Balto, Md.</b>				24. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Baltimore St.</b> 25a. REC'D BY REGISTRAR <b>MAY 5 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06770					06763				
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>15 da.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>06-1</b> d. STREET ADDRESS <b>No fixed address</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Owen</b> Middle <b>Alexander</b> Last <b>King</b>			4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>1966</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>9-28-80</b> 9. AGE (in years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>212-32-1431</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease</b> <b>4200</b> DUE TO (b) <b>Emphysema</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 11</b> , 19 <b>66</b> , to <b>May 26</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 26</b> , 19 <b>66</b> , and that death occurred at <b>7:30</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Ernest Beiser M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>ERNEST BEISER M.D.</b>								22b. DATE SIGNED <b>5-26-66</b> 22d. ADDRESS <b>Springfield State Hosp. Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		23d. LOCATION (City, town or county) (State) <b>Carroll Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Nancy Haight Sykesville, Md.</b>						25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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*Ernest Beiser M.D.*

ERNEST BEISER M.D.

*100788*

*May 11 1966*

*May 20 1966*



06771

## CERTIFICATE OF DEATH

06764

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>8yrs. 10mos. 2dys.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>2002 Park Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HELEN CONSTANCE KLEIN</b>			4. DATE OF DEATH Month Day Year <b>MAY 5 19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-14</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Thomas Baran</b>		
14. MOTHER'S MAIDEN NAME <b>Frances (last name unk.)</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>Unk.</b>			17. INFORMANT Address <b>Records, Springfield State Hospital</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> DUE TO (b) <b>Uremia</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with convulsive disorder, with psychotic reaction</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-3-57</b> , 19__, to <b>5-5-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-5-66</b> , 19__, and that death occurred at <b>8:50 AM</b> , from causes on and on the date stated above.					
22a. SIGNATURE <b>Dr. Antonius Glahn</b>		22b. DATE SIGNED <b>5-5-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M. D.</b>	
22d. ADDRESS <b>Springfield State Hospital</b>		22e. ADDRESS <b>Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Freedom Cemetery</b>	
23d. LOCATION (City or Town) <b>Sykesville, Md.</b>		23e. LOCATION (County) (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>		24a. ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 10 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the certificate and should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06772					06763						
1. PLACE OF DEATH a. COUNTY <i>Carsel</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carsel</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester, md.</i>			c. LENGTH OF STAY IN 1b <i>2 mo</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster, md Rd #106-1</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Longview Nursing Home</i>					d. STREET ADDRESS <i>none</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>VERONICA C. Lister</i>					4. DATE OF DEATH Month Day Year <i>May 21 1966</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 28, 1887</i>		9. AGE (In years last birthday) <i>79</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Gasemier Pietzack</i>					14. MOTHER'S MAIDEN NAME <i>Anna Kosowski</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>213-07-8956D</i>					17. INFLUENZA <i>no</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio Vascular</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Bronchitis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary fibrosis generalized</i>										INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i> <i>7 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <i>1955</i> to <i>5/21</i> , 1966, that (1) (we) last saw the deceased alive on <i>5/21</i> , 1966, and that death occurred at <i>4:45</i> AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>W. H. Foard</i>					22b. DATE SIGNED <i>5/21/66</i>						
22c. PHYSICIAN'S NAME (Type) <i>W. H. FOARD M.D.</i>					22d. ADDRESS <i>Manchester, md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIED</i>			23b. DATE THEREOF <i>5/25/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cem.</i>			23d. LOCATION (City, town or county) (State) <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR <i>B. Dobrowski</i>					ADDRESS <i>2816 E. Baltimore St.</i>		25a. REC'D BY REGISTRAR <i>MAY 25 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MAY 3 1966

## CERTIFICATE OF DEATH

06773

06766

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Finks Westminister</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL Co. Hospital</b>		d. STREET ADDRESS <b>Route 2</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Florence</b> Last <b>Ludwig</b>		4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-1890</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Wilson</b>		14. MOTHER'S MARDEN NAME <b>Selby Bull</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mr. Frederick Ludwig</b>		Address <b>Finksburg</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>YEARS</b> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> , 1966, to <b>5/19</b> , 1966, that (I) (we) last saw the deceased alive on <b>5/19</b> , 1966, and that death occurred at <b>8:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Vincent J. Fiocco Jr.</b>		22b. DATE SIGNED <b>5/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Vincent Fiocco, Jr.</b>		22d. ADDRESS <b>Westminister, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-22-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New OAKland Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Sykesville Md.</b>
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>	
ADDRESS <b>Sykesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate, and the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>45y. 7m. 9d.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1810 Hope Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Gabriella</b> Middle <b>?</b> Last <b>Masopust</b>		4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1885</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Panek</b>		14. MOTHER'S MAIDEN NAME <b>Sodek</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, hebephrenic type.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>10/16/</b> , 19 <b>20</b> , to <b>5/25/</b> , 19 <b>66</b> , that <del>the</del> (we) last saw the deceased alive on <b>5/25/</b> , 19 <b>66</b> , and that death occurred at <b>3:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Luis J. Arribas</b>		22b. DATE SIGNED <b>5/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Luis J. Arribas, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital - Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Freedom Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>CARROLL Co. Md.</b>
24. FUNERAL DIRECTOR <b>Nancy Haight</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>	
ADDRESS <b>Sykesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Figure 1

06775

CERTIFICATE OF DEATH

06768

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>27 days.</b> <b>6 yrs./8 mos.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>5506 Stonington Avenue</b> <b>3605 Garrison Blvd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADA MARIE MC CONNELL</b>		4. DATE OF DEATH Month Day Year <b>May 13, 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-94</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>13, 19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical Work</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard F. Gallery</b>		14. MOTHER'S MAIDEN NAME <b>Annie Ross</b> <b>Frederick, Md</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-1963</b>	
17. INFORMANT <b>Agnes M. McConnell-234 Carroll Pkwy</b> <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Livermia</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic CKD years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-18-59</b> , 19__ to <b>5-13-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-13-66</b> , 19__, and that death occurred at <b>9:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Antonius Glahn, M.D.</b>		22b. DATE SIGNED <b>5-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital</b> <b>Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-17-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery - Baltimore, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3mos.19dys.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>AMANDA</b>		First <b>MAE</b>		Middle <b>MEANS</b>		Last <b>MEANS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-21-1891</b>		9. AGE (In years last birthday) <b>74</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Amos Ines</b>				14. MOTHER'S MAIDEN NAME <b>Susan Bennett</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-36-6994</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic Infection</b> 334X DUE TO <b>dissecting Ulcers</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Chronic Brain Syndrome</b> (c) <b>Cerebral Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Paralysis Agitans</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b> <b>weeks</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Happened in Springfield</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3/16</b> 19 <b>66</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wayfield Avenue Sykesville Carroll Md</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>		EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M. D.</b>		M.D.		22. DATE SIGNED <b>5-1-66 md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>May 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>South Hampton, PA.</b>					
24. FUNERAL DIRECTOR <b>Harry W. Knight</b>		ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



CASE 20

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster RD #3</b> c. LENGTH OF STAY IN 1b <b>62 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster RD #3</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>LUTHER</b> Last <b>MENCHEY, SR.</b>					4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1966</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 11, 1903</b>		9. AGE (in years last birthday) <b>62</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>James E. Menchey</b>					14. MOTHER'S MAIDEN NAME <b>Vertie M. Barnhart</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>					16. SOCIAL SECURITY NO. <b>218-14-6265</b>		17. INFORMANT <b>Mrs. Grace Koontz Menchey</b> Address <b>same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Atrophic pt. kidney - hypertension</b>								INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> to <b>April 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 20, 1966</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Philip W. Mercer</b> 22c. PHYSICIAN'S NAME (Type) <b>PHILIP W. MERCER</b>					M.D. <b>W. MAIN ST. WESTMINSTER, MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Leister's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Westminster RD #3 Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Smyer, Jr., Westminster, Md</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 6377 5/26/66  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06771

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>1mo.27dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>12411 Atherton Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>(NMN)</b> Last <b>METZLER</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-16-27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Masseur</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>38</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Franklin Metzler</b>				14. MOTHER'S MAIDEN NAME <b>Sceola Broome</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> 8749 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Complete diagnosis pending toxicology/examination</b> DUE TO <b>Poisoning due to lethal dose of Doriden</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						INTERVAL BETWEEN ONSET AND DEATH <b>Day</b> <b>day or more</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Glenn Speicher, M.D.</b>				22. DATE SIGNED <b>5/18/66</b>			
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>				22. DEPUTY MEDICAL EXAMINER <b>1356 Main St. Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>may 11, 1966</b>		23b. DATE THEREOF <b>may 11, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery, Pa.</b>		23d. LOCATION (City, town or county) (State) <b>North Country Twp. Ches. Penna.</b>	
24. FUNERAL DIRECTOR <b>Arthur H. Haight, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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MEMORANDUM FOR THE DIRECTOR OF THE FBI

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06779					06772				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Carroll		MARYLAND			Maryland		Carroll		
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?		
Rural - Finksburg		Lifetime			Rural - Finksburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
Henry		A.		Miller		May		15 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M		W				May 17, 1910		55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Contractors				Part-time Bldg.		Carroll Co., Md.		U. S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Richard Miller					Myrtle Mann				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		216-14-5926		Mrs. Ruth Miller		Finksburg, Md. R.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Adeno-carcinomatosis 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary mucinous adeno-carcinoma of rectum DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH App. 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. --- 19--		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 20, 1964, to May 15, 1966, that (I) (we) last saw the deceased alive on May 15, 1966, and that death occurred at A.M. from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
		Joseph E. Bush, M.D.		5/16/66		Hampstead, Maryland 21074			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		5/18/66		Wesley Cemetery		Carroll Co. Md.			
24. FUNERAL DIRECTOR		25a. REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE			
Tipton-Eline		Hampstead, Md.		MAY 20 1966					

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MAY 20 1966



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Taney Drive</b>		d. STREET ADDRESS <b>Taney Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Gertie Beula Moyer</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1885</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>06</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Allentown, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin Kramer</b>		14. MOTHER'S MAIDEN NAME <b>Annie Lembach</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>171-05-2635</b>	
17. INFORMANT <b>Mr. Wilbur Moyer, Taneytown, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Urinary organs (c)</b> 1817 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition, senility, marked anemia</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. Ambler Thompson</b> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. Ambler Thompson, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>49 Frederick St., Taneytown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Allentown, Penna.</b>	
23. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son (John H. Skiles)</b>		24a. REC'D BY REGISTRAR <b>MAY 31 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>John H. Skiles</b>		24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

WATKINS & COMPANY  
MEDICAL EXAMINERS  
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1935

WATKINS & COMPANY  
MEDICAL EXAMINERS  
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1935

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06781

## CERTIFICATE OF DEATH

06774

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Rural</u> c. LENGTH OF STAY IN 1b <u>1yr. 6mos. 22day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2838 St. Paul Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALLEN</u> First <u>MARTIN</u> Middle <u>MULLAN</u> Last				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>29</u> Year <u>1966</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-13-90</u>	
<b>9. AGE</b> (In years lost birthday) <u>75</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED - clerk</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SALES</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>John Mullan</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen Martin</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-07-1680</u>		<b>17. INFORMANT</b> Address <u>Springfield State Hospital records, Sykesville</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 C.V.A. Thrombosis</u> DUE TO (b) <u>Arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>April 20</u>, 19<u>66</u>, to <u>May 29</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>May 29</u>, 19<u>66</u>, and that death occurred at <u>1:55</u> P.M. from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Suha Ozgun</u>				<b>22b. DATE SIGNED</b> <u>May 29, 66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>SUHA OZGUN</u>	
<b>22d. ADDRESS</b> <u>Springfield State Hosp. Sykesville Md.</u>				<b>22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>6/1/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral</u>		<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Baltimore Md.</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>				<b>25a. REGD BY REGISTRAR</b> DATE <u>MAY 31 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

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MINISTRY OF DEFENSE

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MAY 1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06783

# CERTIFICATE OF DEATH

06776

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>23 yrs./16 das.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>712 Hankin Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Carroll</b> Last <b>NESLINE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-1916</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph B. Nesline</b>				14. MOTHER'S MAIDEN NAME <b>Constance Shaw</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no None</b>		16. SOCIAL SECURITY NO. <b>unkn.</b>		17. INFORMANT Address <b>Springfield State Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>490 X</b> IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumococcus</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, paranoid type. Mental defective undifferntiated.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4-29-63</b> , 19__, to <b>5-15-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-15-66</b> , 19__, and that death occurred at <b>4 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Octavio A Ruiz</b>				22b. DATE SIGNED <b>5-15-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Octavio Ruiz, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>17 May 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Snitland, Maryland</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06784

06777

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> 06-1			
c. LENGTH OF STAY IN 1b <u>YEARS</u>				d. STREET ADDRESS <u>LIGHTNER ST.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LIGHTNER ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALONZO LAWRENCE</u>		First Middle Last		4. DATE OF DEATH <u>MAY 30 1966</u>		Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 10-1904</u> 61 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PACK HOUSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDGAR BLACK</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE NOKES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-03-7790</u>		17. INFORMANT <u>HELEN NOKES</u> Address <u>UNION BRIDGE</u> M.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (acute)</u> 3221 DUE TO (b) <u>Chronic Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				22. DATE SIGNED <u>5/30/66</u>			
EXAMINER'S NAME (Type) <u>W. GLENN SPEICHER</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>135 E. Main St. Union Bridge, Carroll</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT JOY</u>		23d. LOCATION (City, town or county) (State) <u>UNIONTOWN MD</u>	
24. FUNERAL DIRECTOR <u>D D Hartzler &amp; sons Union Bridge</u>				25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

100-100000

DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-100000

100-100000



CERTIFICATE OF DEATH

06785

06778

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN lb <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>272 Washington Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NETTIE E. PARRY</b>		4. DATE OF DEATH <b>May 14, 1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1893</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR: Months <b>06</b> Days <b>14</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Trade, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Bumgardner</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-54-2287</b>	
17. INFORMANT <b>Mrs. Virginia Gist, Cedarhurst, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>4201</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>13 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 13, 1966</b> , to <b>May 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 14, 1966</b> , and that death occurred at <b>6 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John S. Harshey</b>		22b. DATE SIGNED <b>5/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>		22d. ADDRESS <b>8 Anchor St. Westminster, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>5/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Finksburg Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Finksburg, Carroll, Md.</b>
24. FUNERAL DIRECTOR <b>J. Z. Myro, Jr., Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>May 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00373

STATE OF TEXAS

00373

APR 10 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06786 CERTIFICATE OF DEATH 06779

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ross Nursing Home</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville, Md. 06-1</b>			
d. STREET ADDRESS <b>Mineral Hill Rd -</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>R.</b> Last <b>Phillips</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-6-1871</b>	
9. AGE (In years last birthday) <b>95 yrs.</b>		IF UNDER 1 YEAR Months <b>95</b> Days <b>15</b> Hours <b>15</b> Min.		10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Wm H. Phillips</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Frizzell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>Mr. Charles Phillips - Sykesville, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 260X DUE TO <b>H.C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Diabetes mellitus</b> (b) <b>10 yrs.</b> (c) <b>28 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>64</b> , to <b>5-15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-15</b> , 19 <b>66</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>R. V. Houck, Jr.</b>				22b. DATE SIGNED <b>5-17-66</b>		22c. PHYSICIAN'S NAME (Type) <b>R. V. Houck, Jr.</b>	
22d. ADDRESS <b>Liberty Road, Sykesville, Md.</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>5-18-66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Old Oakland Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sykesville Md.</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>				25a. REF'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
25c. ADDRESS <b>Sykesville, Md.</b>				25d. DATE <b>MAY 19 1966</b>			

00773

00773

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "H. O. P. O." and "P. O. Box" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
06787		06780	
1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RD#7</u> c. LENGTH OF STAY IN lb <u>all her life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pleasant Valley</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RD#7</u> d. STREET ADDRESS <u>Pleasant Valley</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCY REBECCA POWELL</u>		4. DATE OF DEATH Month Day Year <u>May 24 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13, 1888</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing factory</u>		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Charles M. Kemper</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-01-175A</u>	
17. INFORMANT <u>Mrs. Russell C. Doherty</u>		Address <u>Westminster Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO (b) <u>Arterio sclerosis &amp; Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>8-10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 196 <u>3</u> to <u>5-24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> , 19 <u>66</u> , and that death occurred at <u>2:20</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Glen N. Speicher</u> M.D.		22b. DATE SIGNED <u>5-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. GLEN N. SPEICHER</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 27 '66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery Westminster RD#7 Md.</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
ADDRESS <u>Westminster, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>MAY 27 1966</u>			

10730

10730

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

MAY 11 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>3 MO.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAGGIE MAY Powell</u>		4. DATE OF DEATH <u>5</u> <u>24</u> <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Noah, Powell</u>		14. MOTHER'S MAIDEN NAME <u>Martha Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-01-1776</u>	
17. INFORMANT <u>Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS HEART DISEASE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOCLEROSIS</u> DUE TO <u>WITHOUT</u> (c) <u>C.B.S. WITH S.B.D. QUALIFYING PHRASE.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>66</u> , to <u>5-24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>R. E. Lojonchere MD</u>		22b. DATE SIGNED <u>5-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. E. LOJONCHERE</u>		22d. ADDRESS <u>S.H. Sykesville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/27/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Westminster Rd7 Md.</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 27 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

60703

60703

State of New York

County of ...

In SENATE,

January 1, 1903.

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

AT ITS SESSION ON JANUARY 1, 1903.

ALBANY:

WEDNESDAY, JANUARY 1, 1903.

RECEIVED

STATE OF NEW YORK

LAND OFFICE

ALBANY

1903





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06789											
06782											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DARLINGTON</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PULLEN NURSING HOME</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ARCHIE SAMUEL PUTMAN</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 13, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONARY ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POWER HOUSE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOAH H. PUTMAN</u>						14. MOTHER'S MAIDEN NAME <u>IDA MAE STOFFER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-26-975</u>		17. INFORMANT Address <u>MRS EMMA B. PUTMAN - ABOVE.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized;</u> DUE TO (c) <u>Hemiplegia, Hypertension</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12-20-65</u> through <u>5/5/66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 20</u> , 19 <u>65</u> , to <u>May 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 5</u> , 19 <u>66</u> , and that death occurred at <u>8:50 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 6, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>						22d. ADDRESS <u>Sykesville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EMMANUEL CHURCH</u>				23d. LOCATION (City, town or county) (State) <u>GLENCOE MD.</u>			
24. FUNERAL DIRECTOR <u>Arthur H. Haight</u>						ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 10 1966</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH					06783				
1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>50 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 E. George St</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 06-1 d. STREET ADDRESS <u>24 E. George St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>LEO</u> Last <u>ROTHENBERGER</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1966</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>64</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber yard employee</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Rural, Westminster, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>David William Rothenberger</u>			14. MOTHER'S MAIDEN NAME <u>Helena Bell</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-01-1708</u>		17. INFORMANT <u>Mrs. D. Leo Rothenberger</u>		Address <u>same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abscess lower colon (Colectomy)</u> DUE TO (c) <u>ates withritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 1/2 years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ates withritis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> 19 <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1964</u> , to <u>5-27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-27</u> , 19 <u>66</u> , and that death occurred at <u>10:30 P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>C. L. Billingslea</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-27-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>				22d. ADDRESS <u>Westminster, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/31/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Westminster, Md.</u>			
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr.</u>				ADDRESS <u>Westminster, Md.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>MAY 31 1966</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06784											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				d. STREET ADDRESS <u>Green St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brookfield Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>THOMAS</u> Middle <u>ROUTZOHN</u> Last						4. DATE OF DEATH <u>MAY 5</u> 19 <u>66</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27, 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ryan Routzohn</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Petry</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>217-12-1486</u>		17. INFORMANT <u>Mrs. Nevin Outrow, Keymar, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral atherosclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Atherosclerotic cardiovascular disease</u> 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 <u>5/5/66</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>11/4/65</u> 19 <u>65</u> , to <u>5/5/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/5/66</u> 19 <u>66</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>J. A. Caricofe</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. J. A. Caricofe</u> 22d. ADDRESS <u>Union Bridge Md.</u> 22b. DATE SIGNED <u>5/5/66</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/7/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Rural, Westminster, Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr., Westminster, Md.</u> ADDRESS <u>-</u> 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>-</u> DATE <u>MAY 10 1966</u>											



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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06785

1. PLACE OF DEATH a. COUNTY Carro 11 MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mt. Airy		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 21-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sandra Lee Motel				d. STREET ADDRESS 51 BROADWAY		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACK		Middle JOYCE		Last RUSE		4. DATE OF DEATH Month May Day 3 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27, 1912	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAX DIVISION		10b. KIND OF BUSINESS OR INDUSTRY STATE OF MARYLAND		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT RUSE				14. MOTHER'S MAIDEN NAME MARY POWLES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-3463		17. INFORMANT FREDERICK, MARYLAND MRS. DORIS GRIFFIN 501 W 2ND. STREET			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 X Gunshot wound Chest mid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Sternal region 3 in above DUE TO (c) Thyroid process						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Self Inflicted Gunshot wound Chest					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5/3 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, city, street, office, etc.) Sandra Lee Motel		20f. (City or town) (County) (State) Mt Airy Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher		EXAMINER'S NAME (Type) W. GLENN SPEICHER		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5/3/66 Charles M. Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 5, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR Charles M. Judge		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester Md.</u> c. LENGTH OF STAY IN 1b <u>mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 128 Union St Manchester</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead, md Rd #1 06-1</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hattie Virginia Schaefer</u> First Middle Last 4. DATE OF DEATH <u>5 21 1966</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/5/1881</u> 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Reisterstown Md. Baltco.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Edward Tinkler</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Croust</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>212-10-8062D</u> 17. INFORMANT <u>Alice Herschkrine</u> Address <u>Hampstead Md Rd #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 1419 DUE TO <u>Pulmonary edema</u> (b) <u>Carcinoma of tongue - metastatic</u> (c) <u>2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>2 years</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> , 19 <u>66</u> to <u>5/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>66</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>Greenmount, Md</u> 22d. ADDRESS _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/25/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Reisterstown Methodist</u> 23d. LOCATION (City, town or county) (State) <u>Reisterstown, Md.</u>		24. FUNERAL DIRECTOR <u>J. F. Eline &amp; Sons</u> ADDRESS <u>Reisterstown, Md.</u> 25a. REC'D BY REGISTRAR <u>MAY 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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5392 J. S. Yang

06796

CERTIFICATE OF DEATH

06787

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|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Carroll</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sykesville</b>   |   | c. LENGTH OF STAY IN 1b<br><b>5yr 8mo</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Springfield State Hospital</b>   |   | d. STREET ADDRESS<br><b>3902 Falt Ave. # 24.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>May</b> Middle <b>Schorr</b> Last   |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>8</b> Year <b>19 66</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-2-1883</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At. Home</b>  | 9. AGE (In years last birthday) yrs.<br><b>83</b>   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Columbus Keys</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mollie</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Springfield State Hosp. Records</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4221 Infected Bed Sores</b><br>DUE TO <b>Arteriosclerotic Cardio-vascular Disease</b><br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO <b>Generalized Arteriosclerosis</b><br>(c) <b>Generalized Arteriosclerosis</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b><br><b>Years</b><br><b>Years</b>                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic Brain Syndrome Associated with senile brain disease</b>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-6-60</b> , 19 <b>to 5-8-66</b> , 19 <b>that (I) (we) last saw the deceased alive on 5-8-66</b> , 19 <b>and that death occurred at 1:25 A.M.</b> , from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>Dr. Antonius Glahn, M.D.</b>   |   | 22b. DATE SIGNED<br><b>5-8-66</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Antonius Glahn, M.D.</b>   |   | 22d. ADDRESS<br><b>Springfield State Hospital Sykesville, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>5-11-66</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>7401 German Hill Rd., Md</b>                  |
| 24. FUNERAL DIRECTOR<br><b>Charles S. Geiler, 901 S. Conkling St. Balto., 21224, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAY 12 1966</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CHURCH OF THE DEAN

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06795

06788

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|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Carroll</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Sykesville</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  |
| c. LENGTH OF STAY IN 1b<br><b>11 mo-2 da</b>   |   | d. STREET ADDRESS<br><b>8510 16th Street</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Springfield State Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ethel Nickerson</b> Middle <b>Shaw</b> Last <b>Shaw</b>  |   | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>1</b> Year <b>19 66</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-6-83</b>   |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>15</b> Days <b>2</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Indiana</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>William H. Nickerson</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Augusta Gilkison</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>578-05-5316</b>   |  |
| 17. INFORMANT<br><b>Springfield Hospital Records; Sykesville, Md</b>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>4221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Arteriosclerosis cardiovascular disease</b><br>DUE TO<br>(c) <b>Chronic brain syndrome associated with arteriosclerosis with neurotic reaction</b> |   |   |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>years</b>  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).<br><b>Chronic brain syndrome associated with arteriosclerosis with neurotic reaction</b>  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-29</b> , 19 <b>65</b> , to <b>5-1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-1</b> , 19 <b>66</b> , and that death occurred at <b>4:20 A</b> M, from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><b>Luis J. Arribas</b>   |   | 22b. DATE SIGNED<br><b>5-1-66</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Luis J. Arribas</b>   |   | 22d. ADDRESS<br><b>Sykesville, Maryland 21784</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>4 May 1966</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Prince George Co., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Humphrey, Inc.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   | DATE<br><b>MAY 10 1966</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06796

# CERTIFICATE OF DEATH

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|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Carroll</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Allegany</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sykesville</b>  |  | c. LENGTH OF STAY IN lb<br><b>11 mos. 9 dys. Cumberland</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Springfield State Hospital</b>  |  | d. STREET ADDRESS<br><b>154 Frederick Street</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ELIZABETH (NMN) SMITH</b>   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>25</b> Year <b>1966</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>10-21-93</b>   |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Robert Walker</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Smith</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Records, Springfield State Hospital</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>491x</b><br><b>0022</b> (b)<br>DUE TO<br>(c) |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><b>Chronic brain syndrome associated with senile brain disease, without qualifying phrase. Inactive pulmonary tuberculosis.</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-16-65</b> , 19__ to <b>5-25-66</b> , 19__, that (I) (we) las saw the deceased alive on <b>5-25-66</b> , 19__, and that death occurred at <b>8:15 P.M.</b> causes and on the date stated above |  |   |   |
| 22a. SIGNATURE<br><b>Agustin del Campo</b>   |  | 22b. DATE SIGNED<br><b>5-26-66</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Agustin del Campo, M.D.</b>   |  | 22d. ADDRESS<br><b>Springfield State Hospital<br/>Sykesville, Maryland 21784</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>May 28, 1966</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bonshar Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Bonshar, Wash. Co. Md</b> |
| 24. FUNERAL DIRECTOR<br><b>John A. Galt Jr.</b>  |  | 25. REC'D BY REGISTRAR<br><b>Charles Judge</b>  |   |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAY 1 1966

CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH<br>a. COUNTY <u>Carroll</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u><br>c. LENGTH OF STAY IN b <u>5 month</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Longview Nursing Home 128 N Main St Manchester, Md</u>  |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <u>md</u><br>b. COUNTY <u>Carroll</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>442 E Baltimore St, Taneytown Md</u><br>d. STREET ADDRESS <u>442 E Baltimore St</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <u>John William Smith</u>   |   | 4. DATE OF DEATH <u>5 12 1966</u>  |   |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>Feb 20, 1885</u>                |
| 9. AGE (In years last birthday) <u>81 yrs.</u>  |   | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>   | 11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming, Real Estate agent.</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wahfield Carroll Co, Md</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Dennis Smith</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Susan Miller</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |   | 16. SOCIAL SECURITY NO. <u>212-32-1319A</u>  |   |
| 17. INFORMANT <u>Elizabeth S. Matthews</u>  |   | Address <u>main st Hampster, Md</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <u>Lymphoma (retroperitoneal)</u><br>2021<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |   | INTERVAL BETWEEN ONSET AND DEATH <u>10 MONTH</u>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 5</u> 19 <u>65</u> to <u>May 12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>66</u> , and that death occurred at <u>3:40 PM</u> from the causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE <u>W H Foard</u>   |   | 22b. DATE SIGNED <u>5/12/66</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard MD</u>  |   | 22d. ADDRESS <u>Manchester, Md</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION (City, town or county) (State)        |
| <u>Burial</u>   | <u>5/15/66</u>  | <u>Frederick Cemetery</u>  | <u>Frederick, Md</u>                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u>  |   | 25a. REC'D BY REGISTRAR <u>MAY 16 1966</u>   |   |
| ADDRESS <u>Westminster, Md</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02540

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06798

06791

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CARROLL</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> COUNTY <b>CARROLL</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>   |  | c. LENGTH OF STAY IN b. <b>1/2 HOUR</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL CO. GEN. HOSP.</b>  |  | e. STREET ADDRESS <b>PENNA AVE</b>   |  |
| 3. NAME OF DECEASED (Type or print) <b>MARY ELIZABETH SMITH</b>   |  | 4. DATE OF DEATH <b>MAY 23 1966</b>  |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 10, 1895</b>                                   |
| 9. AGE (In years last birthday) <b>70</b> yrs.  |  | 10. IF UNDER 1 YEAR Months Days  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Henry Smith</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Addie E. Shoemaker</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>Mr. Donald Clingan, Taneytown, Maryland</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH <b>17 HOURS</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>MAY 1966</b> to <b>MAY 1966</b> , that (I) (we) lost saw the deceased alive on <b>MAY 23 1966</b> , and that death occurred at <b>8:00 AM</b> , from causes on and on the date stated above.                                   |  |  |  |
| 22a. SIGNATURE <b>Daniel I. Welliver</b> M.D.   |  | 22b. DATE SIGNED <b>5-23-66</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>DANIEL I. WELLIVER</b>  |  | 22d. ADDRESS <b>19 RIDGE ROAD WESTMINSTER MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>May 26, 1966</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Taneytown, Maryland</b> |
| 24. FUNERAL DIRECTOR <b>John A. Skiles</b> ADDRESS <b>C.O. Fuss &amp; Son, Taneytown, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>MAY 26 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00191

EXHIBIT OF DEATH

00191

THE STATE OF TEXAS,  
COUNTY OF DALLAS,  
I, the undersigned, Clerk of the County,  
do hereby certify that the within and foregoing  
is a true and correct copy of the original  
as the same appears from the records of the  
County of Dallas, State of Texas.

WITNESSED my hand and the seal of the County of Dallas, State of Texas, this 1st day of May, 1900.

CLERK OF COUNTY

1900 MAY 1

## CERTIFICATE OF DEATH

Reg. Dist. No. 06792

|   |                              |   |   |  |   |   |   |
|---|------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CARROLL</b> MARYLAND  |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>UNION BRIDGE</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>YEARS</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>UNION BRIDGE</b>                                    |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MAIN ST.</b>   |                              |   |   | d. STREET ADDRESS<br><b>MAIN ST.</b>   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>WILLIAM OUSLOW SPRAGUE</b>   |                              |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>MAY 7 1966</b>  |   |   |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG 9 - 1902</b> |  | 9. AGE (In years last birthday) yrs.<br><b>63</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>GANG FOREMAN</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>SAMUEL SPRAGUE</b>  |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><b>AGNES WARNER</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>  |                              | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>WW II 705-10-4911</b>  |   | 17. INFORMANT<br>Address<br><b>DORIS SPRAGUE UNION BRIDGE MD</b>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br><b>163X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(Rt. Lung original site)</b> DUE TO<br>(c) <b>37 days</b> |                              |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Mar 31</b> , 19 <b>44</b> , to <b>5/7/44</b> , 19 <b>44</b> , that I last saw the deceased alive on <b>5/7/44</b> , 19 <b>44</b> , and that death occurred at <b>5:45</b> AM, from the causes and on the date stated above.  |                              |   |   |  |   |   |   |
| ACTUAL SIGNATURE <b>M. E. Robertson</b>   |                              |   |   | ADDRESS (Street, city or town, state)<br><b>New Windsor, Md</b>  |   | DATE SIGNED<br><b>5/7/44</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>M E ROBERTSON</b>   |                              |   |   | <b>NEW WINDSOR MD</b>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                              | 22b. DATE, THEREOF<br><b>5/10/66</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MT VIEW</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>UNION BRIDGE MD</b>                           |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W D Hartzler &amp; Sons</b>  |                              |   |   | ADDRESS<br><b>Union Bridge</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>MAY 10 1966</b>  |   |
|   |                              |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06800

06793

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Carroll</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sykesville</b>   |   | c. LENGTH OF STAY IN 1b<br><b>2 mos./5das.</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21211</b>  |   | 30-4  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Springfield State Hospital</b>   |   | d. STREET ADDRESS<br><b>4450 Newport Avenue</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>NMN</b> Last <b>STIMPSON</b>   |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>1</b> Year <b>1966</b>  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-29-1882</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>84</b>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bricklayer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>England</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Naturalized</b>  |   |
| 13. FATHER'S NAME<br><b>William Stimpson, -dec.</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ann - ? - dec.</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>100-05-8816</b>   |   |
| 17. INFORMANT<br><b>Springfield State Hospital Records</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease.</b><br><b>4221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis.</b><br>DUE TO (c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2-25-66</b> , 19 to <b>5-1-66</b> , 19, that (I) (we) last saw the deceased alive on <b>5-1-66</b> , 19, and that death occurred at <b>2:20 a.m.</b> , from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>Octavio Ruiz</b>   |   | 22b. DATE SIGNED<br><b>5-1-66</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Octavio Ruiz, M.D.</b>   |   | 22d. ADDRESS<br><b>Springfield State Hospital Sykesville, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>4 May 1966</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Burgee Funeral Home 3631 Falls Road</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAY 4 1966</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAY 1 1968

U.S. AIR FORCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06801

CERTIFICATE OF DEATH

06794

|  |                                    |   |   |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>CARROLL</b><br>MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>CARROLL</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WESTMINSTER</b>   |                                    | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>NEW WINDSOR RT# 1 06-1</b>  |                                    | d. STREET ADDRESS<br><b>BOX 197A</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>CARROLL CO. GENERAL HOSP</b>  |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LAWRENCE ROOSEVELT SUMMERS</b>  |                                    | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>19</b> Year <b>1966</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>COLORED</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>DEC. 26 1915</b> |
| 9. AGE (In years last birthday)<br><b>50</b> yrs.  |                                    | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>19</b> Hours <b>19</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CUSTODIAN, MFG. COMPANY</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>WESTMINSTER, MD</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>WILLIAM L. SUMMERS</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>THEODOSIA SUMMERS (DORSEY)</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>216-05-1410</b>  |                                    | 16. SOCIAL SECURITY NO.<br><b>MRS LAWRENCE R. SUMMERS, SAME</b>   |   |
| 17. INFORMANT<br><b>Address</b>  |                                    | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b><br>DUE TO<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>(c) <b>HYPERTENSIVE</b> |   |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>10 HOURS</b>  |                                    | 20. YEARS<br><b>YEARS</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5/19</b> , 19 <b>66</b> , to <b>5/19</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/19</b> , 19 <b>66</b> , and that death occurred at <b>6:18</b> M, from causes and on the date stated above. |                                    |   |   |
| 22a. SIGNATURE<br><b>Vincent J. Acord Jr</b>   |                                    | 22b. DATE SIGNED<br><b>5/19/66</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)   |                                    | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                    | 23b. DATE THEREOF<br><b>5/22/66</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JAMES CEMETERY</b>  |                                    | 23d. LOCATION (City or Town) (County) (State)<br><b>NEW WINDSOR, MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>J. E. Myers, Jr., Westminster, Md.</b>  |                                    | 25a. REC'D BY REGISTRAR<br><b>MAY 23 1966</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                    |   |   |

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UNITED STATES OF AMERICA

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Carroll</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Sykesville</b><br>c. LENGTH OF STAY IN 1b<br><b>25yrs. 5mos. 10dys.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Springfield State Hospital</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>e. STATE<br><b>Maryland</b><br>f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Allegany</b><br>g. STREET ADDRESS<br><b>Sylvan Retreat</b><br>h. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>FLORENCE</b><br>Middle<br><b>(NMN)</b><br>Last<br><b>WADE</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>MAY</b><br>Day<br><b>23</b><br>Year<br><b>19 66</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>7-6-1889</b>                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Charles H. Wade</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lavinia Whittington</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-54-6273</b>  |  |
| 17. INFORMANT<br><b>Records, Springfield State Hospital</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary embolism, cause unknown</b><br><b>465X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Mental deficiency, undifferentiated</b><br><b>Fracture, right hip</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b> |
| 19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |                                  | 19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><b>Apparently was pushed to floor by another patient on "I"</b><br><b>Ward, Warfield Division</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>10:30</b> p.m. <b>5-3-66</b> 19<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                  | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Springfield State Hospital</b>  |  |
| 20e. (City or town)<br><b>Sykesville, Carroll, Md.</b>  |                                  | 20f. (County) (State)<br><b>Carroll, Md.</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>   |                                  |  |  |
| ACTUAL SIGNATURE<br><b>W. Glenn Speicher</b>  |                                  | 22. DATE SIGNED<br><b>5/23/66</b>  |  |
| EXAMINER'S NAME (Type)<br><b>W. Glenn Speicher, M. D.</b>   |                                  | 22a. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>22b. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (City, town, or county)<br><b>135 S. Main St., Frostburg, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>5-26-1966</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>FROSTBURG MEMORIAL</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>FROSTBURG, MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph R. Must Sr. Frostburg, Md.</b>  |                                  | 25. REC'D BY REGISTRAR<br><b>MAY 26 1966</b>   |  |
| 25a. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  | 25b. REGISTRAR'S SIGNATURE   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                       |  |   |  |   |  |   |  |
|--|--|-----------------------|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                       |  |   |  |   |  |   |  |
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| 1. PLACE OF DEATH<br>a. COUNTY<br>CARROLL COUNTY MARYLAND  |  |                       |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>MARYLAND b. COUNTY<br>CARROLL |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>WESTMINSTER.   |  |                       | c. LENGTH OF STAY IN 1b<br>WHILE BEING ADMITTED  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>RURAL RD #6 WESTMINSTER.                       |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>CARROLL COUNTY GEN. HOSP.  |  |                       |  |   | d. STREET ADDRESS<br>OLD WASHINGTON ROAD   |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>JOHN BYRON WAGNER SR.  |  |                       | First Middle Last  |   | 4. DATE OF DEATH<br>MAY 29TH. 1966   |   |  |   |  |
| 5. SEX<br>M  |  | 6. COLOR OR RACE<br>W |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>JULY 25-1887                                      |  | 9. AGE (In years last birthday)<br>78 yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>FARMER  |  |                       |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>FARM -   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>CARROLL COUNTY |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>JOHN THOMAS WAGNER  |  |                       |  |   | 14. MOTHER'S MAIDEN NAME<br>AMELIA SHIPLEY   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>-NO- -NO-   |  |                       |  |   | 16. SOCIAL SECURITY NO.<br>213-42-2992   |   |  |   |  |
|  |  |                       |  |   | 17. INFORMANT<br>Address<br>RD #6 WIFE MRS. LENAM. WAGNER WESTMINSTER.   |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4222 DUE TO Pneumonia (Viral)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis (Chn)<br>DUE TO (c) |  |                       |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>4 days  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                       |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19  |  |                       | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                           |   |  |
| 21. I certify that (I) (the hospital) attended the deceased from 1940, 19 to 5-29-1966, that (I) (we) last saw the deceased alive on 5-29-1966, and that death occurred at 3:45 PM, from the causes and on the date stated above.  |  |                       |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br>DR. W.C. JENNETTE  |  |                       |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/>                                |  | STAFF PHYS. <input type="checkbox"/>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>DR. W.C. JENNETTE  |  |                       |  | 22d. ADDRESS<br>103 E. MAIN ST. WESTMINSTER, MD   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  |                       | 23b. DATE THEREOF<br>6/12/66   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ZION CHURCH CEM.   |   | 23d. LOCATION (City, town or county) (State)<br>CARROLL CO. MD |   |  |
| 24. FUNERAL DIRECTOR<br>James E. Saffell Jr.   |  |                       |  | ADDRESS<br>WESTMINSTER, MD  |  | 25a. REC'D BY REGISTRAR<br>JUN 1 1966                                 |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |

1. Name of deceased  
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## CERTIFICATE OF DEATH

06804

06797

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| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Carroll</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sykesville</b>                                |  | c. LENGTH OF STAY IN 1b<br><b>39 years</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>City</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Springfield State Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>2816 Waterview Avenue</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>William</b>   |  | First<br><b>William</b>  |  | Middle<br><b>ROBERT P.</b>  |  | Last<br><b>WALL</b>  |  | 4. DATE OF DEATH<br>Month<br><b>5</b> Day<br><b>28</b> Year<br><b>1966</b>                        |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9/13/02</b>   |  | 9. AGE (In years last birthday)<br><b>63</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Never worked</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland (Baltimore)</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Elmer G. P Henicie</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Jennie <del>ROBERT</del> Robinson</b>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br>Address<br><b>Springfield State Hosp. Records Sykesville</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b><br><b>4221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO<br>(c) <b>5 yrs</b> |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hours</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>UREMIA Dementia Precox - Catatonic type</b>  |  |  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-10</b> , 1927, to <b>5-28</b> , 1966, that (I) (we) last saw the deceased alive on <b>5/28</b> 1966, and that death occurred at <b>12:35 AM</b> , from causes and on the date stated above.   |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>SP Wise III</b>   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>5-28-66</b>  |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Samuel P. Wise III</b>  |  | 22d. ADDRESS<br><b>Springfield State Hosp. Sykesville Md.</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>6/1/66</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm F. Tucker &amp; Sons Inc North &amp; Pa Ave</b>  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 31 1966</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Jones</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Carroll</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> |                               | c. LENGTH OF STAY IN 1b<br><b>1 mo. 5 dys.</b>  |                                | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>                                      |                               |   |                                | d. STREET ADDRESS <b>3024 Auchentoroly Terrace</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>HERBERT LEE WILLIAMS</b>   |                               | 4. DATE OF DEATH <b>MAY 6 19 66</b>   |                                | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>5-1-20</b> |   | 9. AGE (In years last birthday) <b>46</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Helper</b>                                   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |                                | 11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>   |  |
| 13. FATHER'S NAME <b>Lee Langston Williams</b>  |                               |   |                                | 14. MOTHER'S MAIDEN NAME <b>Lellia Scott</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>230-32-2657</b>  |                                | 17. INFORMANT <b>Records, Springfield State Hospital</b>  |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4340 Congestive heart failure</b><br>DUE TO (b) <b>Severe kyphoscoliosis (causing marked deformity of thorax)</b><br>DUE TO (c) _____ |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |  | 21. I certify that (I) (this hospital) attended the deceased from <b>3-31-66</b> , 19____, to <b>5-6-66</b> , 19____, that (I) (we) last saw the deceased alive on <b>5-6-66</b> , 19____, and that death occurred at <b>1:45 PM</b> from causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE <b>Octavio A. Ruiz</b>  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  | 22b. DATE SIGNED <b>5-6-66</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>   |  | 22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>  |  |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b> |  | 23b. DATE THEREOF <b>5-12-66</b>                |  | 23c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>       |  |
| 23d. LOCATION (City or Town) <b>Baltimore, Md.</b>      |  | (County) _____ (State) _____                    |  | 24. FUNERAL DIRECTOR <b>Carroll Funeral Home Sykesville - 8-24-66</b> |  |
| 25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>              |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1998

2092

doi:10.1017/S0022278X12000502

528 J. S. Dyer

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06806

CERTIFICATE OF DEATH

06799

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Carroll</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Allegany</b>              |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sykesville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>6 yrs. 10 mo. 17 da. Cumberland</b>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Springfield State Hospital</b>  |                                  | d. STREET ADDRESS<br><b>214 Columbia Street</b>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Edward Joseph</b> Last <b>Williams</b>  |                                  | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>13</b> Year <b>19 66</b>  |                                    |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-17-04</b> |
| 9. AGE (In years last birthday)<br><b>62</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>13</b> Days <b>19</b> Hours <b>66</b> Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant Seaman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>Bernard Williams</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Sanders</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>525-05-1384</b>   |                                    |
| 17. INFORMANT<br><b>Springfield State Hospital records</b>   |                                  | Address   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery insufficiency</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b><br>(b) <b>Severe coronary arteriosclerosis</b><br>DUE TO<br>(c) <b>Bronchopneumonia, bilateral</b> |                                  |   |                                    |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b><br><b>Years</b><br><b>Days</b>   |                                  |   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic brain syndrome associated with alcohol intoxication with psychotic reaction</b>  |                                  |   |                                    |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-29</b> 19 <b>59</b> , to <b>5-13</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-13-</b> 19 <b>66</b> , and that death occurred at <b>2:05am</b> , from causes and on the date stated above.   |                                  |   |                                    |
| 22a. SIGNATURE<br><i>[Signature]</i>   |                                  | 22b. DATE SIGNED<br><b>5-13-66</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. D. Arengo, M.D.</b>  |                                  | 22d. ADDRESS<br><b>Springfield State Hospital</b>   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>MAY 16, 1966</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PATRICKS CEMETERY</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>CUMBERLAND MD.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>BYRON KIGHT</b>   |                                  | 25a. DEATH BY REGISTRAR<br><b>MAY 17 1966</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                                  |   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

06807

06800

|   |                                  |   |                                    |  |   |  |  |
|---|----------------------------------|---|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Carroll</b> MARYLAND  |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sykesville</b>   |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><b>14 days</b>  |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Springfield State Hospital</b>   |                                  |   |                                    | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Raymond</b> Middle <b>Alfred</b> Last <b>Yingling</b>   |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>12</b> Year <b>66</b>  |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-12-91</b> | 9. AGE (In years lost birthday)<br><b>75</b> yrs.  | IF UNDER 1 Year<br>Months <b>12</b> Days <b>19</b> Hours <b>66</b> Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Railroad Carman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                        |  |
| 13. FATHER'S NAME<br><b>Alfred Yingling</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Addie McGee</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes W.W.I</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>705-10-6755</b>   |                                    | 17. INFORMANT<br><b>Springfield State Hospital records</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br>DUE TO <b>4200</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Arteriosclerosis</b><br>DUE TO<br>(c) <b>Old and recent subdural hematomas</b> |                                  |   |                                    |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT, NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic brain syndrome associated with brain trauma, gross force, (subdural hematoma), with psychotic reaction</b>   |                                  |   |                                    |  |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |                                    |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4-28</b> , 19 <b>66</b> , to <b>5-12</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-12-1966</b> , and that death occurred on <b>5-12-1966</b> at <b>8:20 PM</b> , from causes and on the date stated above.  |                                  |   |                                    |  |   |  |  |
| 22a. SIGNATURE<br><i>Michael...</i>   |                                  |   |                                    | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>       |   | 22b. DATE SIGNED<br><b>5-13-66</b>                                   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. D. Arengo, M.D.</b>   |                                  |   |                                    | 22d. ADDRESS<br><b>Springfield State Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>5/15/1966</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LUTHERAN CEM.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>UNIONTOWN MD</b> |  |
| 24. FUNERAL DIRECTOR<br><b>W.D. Hartzler &amp; Sons Union Bridge Md.</b>  |                                  |   |                                    | 25a. REC'D BY REGISTRAR<br><b>MAY 16 1966</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 16 1968

Springfield State Hospital

A. J. Sweeney, M.D.

5:50 p.m. 5-11-68

11-50

On this date, the patient was seen in the clinic, and the following information was obtained:

On 5-11-68, the patient was seen in the clinic.

Springfield State Hospital

5-10-68

W.H.

Admitted 11-1-67

Bed Room

Room 121

11-15-61

Male

Admitted

Springfield

Springfield

Springfield State Hospital

Room 121

Springfield

Springfield

Springfield

Springfield

Springfield

Springfield

11-15-61

CERTIFICATE OF DEATH

11-15-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |   |   |  |   |  |   |  |
|---|--|----------------------------------|---|---|---|---|--|---|--|---|--|
| 06808   |  |                                  |   |   | 06801   |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Carroll</i>  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>md.</i> b. COUNTY<br><i>Carroll</i> |   |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Manchester, md.</i>  |  |                                  | c. LENGTH OF STAY IN 1b<br><i>2 mo.</i>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Hampstead, md.</i>                                   |   |  | d. STREET ADDRESS<br><i>Rd #2 21074</i>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Longview Nursing Home Manchester, md.</i>  |  |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <i>McLivia</i>   |  |                                  | First Middle Last<br><i>Belle Zeigman</i>   |   | 4. DATE OF DEATH<br>Month Day Year<br><i>May 16 1966</i>  |   |  |   |  |   |  |
| 5. SEX<br><i>Female</i>   |  | 6. COLOR OR RACE<br><i>white</i> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><i>May 27, 1883</i> |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><i>82 yrs.</i> Months Days Hours Min. |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Beets, CO. W. Va.</i>   |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |   |  |
| 13. FATHER'S NAME<br><i>John M. Bond</i>  |  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Elizabeth Painter</i>  |   |   |   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>no</i>  |  |                                  | 16. SOCIAL SECURITY NO.<br><i>217-48-2619</i>   |   | 17. INFORMANT <i>Robert Smith</i> Address <i>upper Buckhigrove Rd. Hampstead, md RA #2</i>  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i><br>4221 DUE TO <i>Coronary Artery Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <i>Coronary Artery Disease</i><br>(c) <i>Coronary Artery Disease</i> |  |                                  |   |   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                  |   |   |   |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <i>19</i>  |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                 |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1</i> , 19 <i>55</i> , to <i>May 16</i> , 1966, that (I) (we) last saw the deceased alive on <i>May 14</i> , 1966, and that death occurred at <i>11:30</i> AM, from the causes and on the date stated above.   |  |                                  |   |   |   |   |  |   |  |   |  |
| 22a. SIGNATURE<br><i>Joseph E. Bush</i>   |  |                                  | 22b. DATE SIGNED<br><i>5/16/66</i>  |   |   |   |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>Joseph E. Bush MD</i>  |  |                                  | 22d. ADDRESS<br><i>Hampstead Md.</i>  |   |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |                                  | 23b. DATE THEREOF<br><i>5/19/66</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Stiltz Cemetery</i>  |   | 23d. LOCATION (City, town or county) (State)<br><i>Glen Rock Pa.</i> |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Tipton-Eline</i>   |  |                                  | ADDRESS<br><i>Hampstead, Md.</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><i>MAY 20 1966</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |   |  |   |  |

20370

20370

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MAY 20 1956" and "WATERGATE, Md." are faintly visible.]*

WATERGATE, Md. MAY 20 1956